STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155203	A. BUILDING _____ B. WING _____	C 01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CENTRE FOR HEALTH AND REHABILITATION	203 SPARKS AVENUE JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for Investigation of Complaint IN00084571. Complaint IN00084571 - Substantiated, Federal/state deficiencies related to the allegations are cited at F250, F272, F280 and F323. Survey dates: 1/11/11 and 1/12/11 Facility number: 000110 Provider number: 155203 AIM number: 100271120 Survey team: Jennie Bartelt, RN Census bed type: SNF: 0 SNF/NF: 78 Total: 78 Census payor type: Medicare: 11 Medicaid: 58 Other: 9 Total: 78 Sample: 5 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 1/19/11 by Suzanne Williams, RN	F 000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest	F 250	**F250** *Requires the facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.* The facility will ensure this requirement is met through the following:	

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LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/4/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 250	Continued From page 1 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure social services assisted staff to plan for management of behaviors for a resident who smoked and was at risk for elopement. The deficient practice affected 1 of 1 resident reviewed related to a smoking agreement and 1 of 5 residents at risk for elopement (Resident C) in a sample of 5 residents. Findings include: A. During the Initial Tour on 1/11/11 at 10:00 a.m. residents were observed exiting the facility onto the patio for a smoke break. A uniformed staff person was pulling a cooler on wheels out of the building. During interview at this time, the staff person identified herself as a dietary employee, Employee #3, and another staff person identified herself as a CNA, CNA #6. Taped to the top of the cooler pulled by Dietary Employee #3 was a hand-printed sign that indicated, "12/29/10 per [named of Director of Nursing] [name of Resident C] to have (1) cigg [sic] per smoking session. All others only (2) ciggs per smoking session." Resident C was not observed on the patio smoking at this time. The clinical record for Resident C was reviewed on 1/11/11 at 2:00 p.m. The record indicated the resident was admitted on 12/8/10. Diagnoses included, but were not limited to, dementia,	F 250	1. Resident C was not harmed. 2. All residents who smoke and have the risk of elopement have the potential to be affected. 3. Resident Rights, Smoking policy, Mood and Behavior Program were reviewed with no changes made (See Attachments A, B, and C). Elopement Risk Assessment policy reviewed and updated to include Elopement Binders (See Attachment D). All staff were in-serviced on Resident Rights, smoking policy, mood and behavior program, and Elopement Risk Assessment Procedure on 1-28-11. 4. The Administrator or designee will utilize the Administrative Audit Tool (See Attachment E) to ensure staff is aware of how to properly locate interventions for resident	

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F 250	Continued From page 2 depression, obsessive compulsive disorder, bipolar disorder, and history of tobacco and alcohol use. The Social History and Psychosocial Assessment dated 12/8/10, indicated in the section for "Social Involvement/Interests/Hobbies, How did resident spend their days? Describe past customary routines: ...smoke...." The Initial Social Services Assessment dated 12/10/10 indicated the resident's mood indicators included, but were not limited to, "Repetitive questions re: smoking times...." The facility policy titled "Hillcrest Centre Resident Smoking Policy Updated 7-10-08" was included in the resident's record and was signed by the resident on 12/10/10. "Safe Smoking," item #9 indicated, "A resident may smoke however many cigarettes he or she are [sic] capable of smoking within the allotted smoking time (2, 3, etc.). If the resident has a lit cigarette at the end of the allotted smoking time, the cigarette must be put out." A Smoking Assessment dated 12/9/10 with review date of 12/16/10 indicated, "Rep [repetitive] questions r/t [related to] smoke time, Hx [history] of unsafe smoking 12/15/10." Nurse's Note dated 12/16/10 at 1:10 p.m. indicated, "...Resident continues to badger staff regarding...smoke breaks." A Behavioral Contract signed by the resident and Social Worker dated 12/16/10, included, but was not limited to, related to behaviors, "Non-compliance with smoking policy," and "I	F 250	specific behaviors. Audits will be conducted 5 days a week times 4 weeks, then weekly times 4 weeks, then every 2 weeks times 2 months, then quarterly times 2 quarters. The audits will be reviewed during the facility's quarterly quality assurance meeting and issues will be addressed and the above plan will be altered accordingly. 5. The above plan of correction will be completed on or before February 11, 2011.	

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have agreed to 1. Smoke at designated times & locations, per policy/signed...." The document indicated, "I am willing to work with the staff to improve on them [behaviors]. The staff will provide me with 1. Problem solving techniques, 2. Solutions to resolve these issues, 3. Praise, 4. Support, 5. Verbal reminders, 6. Reassurance as needed, 7. Resident teaching/education on safety concerns."

A Social Service Progress Note dated 12/16/10 (no time indicated) indicated, "Follow-up MDS [Minimum Data Set] [assessment] interview. Res. is a tobacco user. When asked if he would like information on quitting res responded, No, I've smoked for as long as I can remember. Res's wishes to be honored. Res. placed on bx [behavior] contract, family aware. Will continue to monitor."

The record included a Careplan Worksheet with "Problem: Non-Compliance with Smoking Policy," dated 12/16/10 and 1/6/11. The goal indicated, "Compliance with smoking policy thru [through] next review." Interventions included, but were not limited to, "Remind res [resident] of agreement w/[with] brother/POA [power of attorney] of 1 cigarette per break prn [as needed]." Documentation failed to indicate details of the resident's agreement with the brother to smoke only one cigarette at each smoke break or a plan if the resident wished to smoke more cigarettes.

The admission Minimum Data Set assessment dated 12/16/10 indicated in the section for Behavioral Symptoms: "Supporting Documentation:" "Res [resident] has become verbally aggressive with staff, unprovoked with

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F 250	Continued From page 4 purpose r/t [related to] smoke breaks and smoking policy." The "Analysis of Findings" indicated, "Res. has become aggressive during smoke breaks...." "Care Plan Considerations" indicated, "Careplans will be developed per company policy to address physical and psychosocial well-being." Mood and Behavior Communication Memos indicated the following in the section titled, "Provide detailed information on the mood and/or behavior that the resident was experiencing:" 12/9/10 (time not indicated): "Resident continually asking when next smoke time is....At times showing impatience with staff when wants not met immediately." 12/16/10 at 5:15 p.m., "I had taken residents out to smoke when 15 min. [minutes] had passed [name of Resident C] ask [sic] for a cig [cigarette], and when I told him no we had to go back in he told me he won't eat without a cig, and he was going to a cig [sic] from me if I didn't give him one." The possible trigger of the behavior indicated, "Wanted a cigarette." 12/16/10 at 8:00 p.m., "Resident went to shower room to use the B/R [bathroom] because was out of order - activity director walked by shower room & smelled smoke - res. already went back to his room across the hall. When confronted, he admitted to smoking in that shower room & gave me his cigarettes & lighter. Explained the importance of not smoking in the building & observing smoke times, stated understanding." The possible trigger for the behavior indicated, "Wanted to go smoke but it wasn't smoke time yet."	F 250		

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F 250	Continued From page 5 12/17/10 at 6:00 p.m., "Took him out to smoke, and he didn't want his smokes, wanted other residents cigs, when I told him here was his smokes, and he couldn't have the other residents. He then got into my face, and told me he was going to take the cigs if he has to. I had someone go get the nurse, when the nurse [name] came out she told him he couldn't have them, he then set back down. Telling me I will get those cigs. Then I saw him take cigs out of his pockets. When nurse checked she couldn't find them." The possible trigger of the behavior indicated, "Wanting other cigs." A psychiatric consult visit note dated 12/20/10 indicated, "...Cont. [continues] fixated on smoking break, cigs & money needs." Mood and Behavior Communication Memos indicated the following in the section titled, "Provide detailed information on the mood and/or behavior that the resident was experiencing:" 12/28/10 at 6:05 a.m., "It was 6:05 AM I told (names of three residents including Resident C) that we didn't have time to smoke the third cigarette. [Names of two residents] gave me back the cigarettes and [name of Resident C] lite [sic] his cigarette off another one he had and wouldn't put it out and he kept smoking and I repatly [sic] to him that he just kept smoking." The possible trigger of the behavior indicated, "Unknown." On 12/30/10 a physician's order was received for "May send to behavioral unit for evaluation & tx [treatment]." The History and Physical at the behavior center,	F 250		

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dated 12/31/10 indicated, "History of Present Illness: ...More recently, he has been seen to be increasingly agitated and has been having behavioral problems. He has been stealing money and he has been intrusive and med [medication] seeking, and has been difficult to be redirected. He also smokes cigarettes and drinks diet coke constantly...."

The resident was readmitted to the facility on 1/5/11.

Mood and Behavior Communication Memos indicated the following in the section titled, "Provide detailed information on the mood and/or behavior that the resident was experiencing:" 1/5/11 at 6:00 p.m., "CNA took smokers at [sic] when they all got outside [name of Resident C] was telling CNA he got to smoke 3 cigs when CNA told him he can only have 1. He got mad and started yelling (I get 3 cigs) CNA told him her boss had a note on the smoke box, and read it to him, and told him she had to do what she told. Resident wouldn't hear what she was saying. [sic]"

A Care Plan Worksheet for "Problem: Mood and Behavior Care Plan" indicated dates of 12/10/10, 12/14/10 and 1/6/11 with "Problem: Resident presents with primary diagnosis of dementia, depression, bipolar disorder, hx [history] of ETOH [alcohol] abuse, OCD [obsessive compulsive disorder), and may exhibit any or all of the following moods and behaviors." The list of behaviors included, but was not limited to, "Rep. questions - i.e. smoke breaks...Non-compliance [symbol for with] smoking policy." The Goal was "Episodes of moods and behaviors will be redirected and/or diffused daily thru [through] next

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review." Interventions included, but were not limited to, "Bx [behavior contract] in place." Documentation failed to indicate the plan had been updated with specific interventions to address the problems indicated during smoke breaks.

During interview completed on 1/11/11 at 12:45 p.m., the facility's Nurse Consultant #1 indicated the resident eloped from the facility on 1/8/11. She indicated that during the investigation into the elopement, another resident told her Resident C said "he was going to [name of city across river in another state] to smoke what he wanted to smoke." The Nurse Consultant also indicated she was told by the facility's Admissions Coordinator that when she visited Resident C in the acute care hospital after the elopement, the resident indicated he was getting back at his brother related to the decrease in his cigarettes.

During interview with the Social Worker and Social Services/Activities Consultant on 1/11/11 at 3:05 p.m., the Consultant indicated the resident had made a deal with his brother to smoke only one cigarette at each smoke break, and the facility had encouraged the resident to smoke just one cigarette.

During interview completed 1/12/11 at 4:00 p.m. with Nurse Consultant #1 and the Social Worker, the Nurse Consultant indicated she thought the resident's brother and Power of Attorney wanted the resident to smoke only one cigarette due to money issues. She indicated the staff would give the resident more cigarettes if he asked for them, since they were his, and staff wanted to collect money to buy him cigarettes. She also indicated the facility was concerned about infringing on the

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resident's rights if he weren't allowed to smoke his cigarettes. The Social Worker indicated no specific interventions had been planned to assist the staff to deal with the one-cigarette agreement, and no family meeting or care planning had taken place related to the one-cigarette agreement.

B. An interview was completed on 1/11/11 at 12:45 p.m. with the facility's Nurse Consultant #1 and Nurse Consultant #2, the Administrator, and the Director of Nursing. During the interview, Nurse Consultant #1 provided a binder containing documentation related to the elopement of Resident C on 1/8/11.

An Elopement Risk Assessment dated 12/8/10 indicated "Yes" answers to the following questions: "Is the resident cognitively impaired with poor decision making skills?, Does the resident have a diagnosis of dementia, OBS [organic brain syndrome] Alzheimers, delusions, hallucinations, anxiety, depression, or schizophrenia?, Does the resident ambulate independently, with or without the use of an assistive device?", and "Does the resident wander aimlessly?". Next to the question, "Is the wandering behavior a pattern or routine tied to resident's past? was written: "Possibly." Next to the question, "Has the resident been recently admitted or readmitted (within past 30 days) and not accepting of the situation?" was written: "New admit." On the reverse side of the assessment in the section for "Summary of Assessment" was marked with a checkmark: "Resident at risk for elopement, as evidenced by: dementia, depression, hx [history] of wandering aimlessly, ambulates independently. Next to "Appropriate interventions have been:" was a checkmark next to "Initiated." Interventions selected for initiation

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were: "1. Personal safety alarm devices, 2. Exit and stairwell alarms, and 4. Frequent monitoring. Check every [handwritten in blank space was the word] hour." The assessment was signed by a nurse.

Admission Orders and Plan of Care dated 12/8/10, signed but not dated by the physician, included, but were not limited to, "Wanderguard [Departure Alert System] rt. [right] wrist - check placement q [every] shift." The nurse signed "Above orders verified per telephone with physician" with the date written is as: "12/[blank space]/10."

An Elopement Risk Assessment dated 12/10/10 indicated a check mark next to "Yes" answers to the following questions: "Is the resident cognitively impaired with poor decision making skills?, Does the resident have a diagnosis of dementia, OBS [organic brain syndrome] Alzheimers, delusions, hallucinations, anxiety, depression, or schizophrenia?, Does the resident ambulate independently, with or without the use of an assistive device?", and "Does the resident wander aimlessly?". Next to the question, "Is the wandering behavior a pattern or routine tied to resident's past?" where "Possibly" was written was a checkmark. Next to the question, "Has the resident been recently admitted or readmitted (within past 30 days) and not accepting of the situation?" where "New admit" was written was a checkmark. On the reverse side of the assessment in the section for "Summary of Assessment" was marked with a checkmark: "Resident at risk for elopement, as evidenced by: wanders/pacing, [arrow pointing down] cognition, ambulates independently." dementia, depression, hx [history] of wandering aimlessly, ambulates

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independently. Next to "Appropriate interventions have been:" was a checkmark next to "reviewed." Interventions selected for review were: "4. Frequent monitoring. Check every [handwritten] hour. 5. Keep behavior logs, 8. Recreational activities, 9. Music, 13. Staff aware of wander risk, 14. Other: [handwritten] Wanderguard." The assessment was signed by the social worker.

Documentation in the record failed to indicate the hourly monitoring of the resident was completed.

During interview on 1/11/11 at 3:05 p.m., the Social Worker and Social Services/Activities Consultant discussed how the decision was made to use the Wanderguard system for this resident on 12/8/10. The Social Services/Activities Consultant indicated that on the day the resident moved into the facility, she was the Administrator at the facility and saw from her office window that the resident went out to his brother's truck as the brother was unloading the resident's belongings to bring into the facility. She indicated she felt the resident needed a Wanderguard at that time and requested it be used, and that the resident would be monitored for a quarter. She indicated she did not document the information.

The admission Minimum Data Set assessment dated 12/16/10 indicated the resident did not have wandering behaviors during the assessment period.

A Care Plan Worksheet indicated a problem dated 12/8/10 for "Resident has been found to be at risk for elopement d/t [due to] depression, dementia, aimlessly wandering." The goal was, "Resident will not leave the facility unattended thru [through] the next review." Interventions

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included, "Complete elopement risk assessment. Use Redirection, distraction and re-orientation when resident attempts to exit bldg [building]. Follow facility policy and procedures. Encourage participation in activities of choice and interest. Ensure all basic needs have been met. Observe for s/s [signs and symptoms] of depression. Mental health services as needed or ordered." Documentation failed to indicate the care plan was updated after 12/8/10.

A Behavioral Contract signed by the resident and Social Worker dated 12/16/10, included, but was not limited to, related to behaviors, "Wandering/Intrusive/Elopement," and "I have agreed to "...2. Not to leave facility without signing out with my responsible party. 3. Not to enter other's rooms, office...." The document indicated, "I am willing to work with the staff to improve on them [behaviors]. The staff will provide me with 1. Problem solving techniques, 2. Solutions to resolve these issues, 3. Praise, 4. Support, 5. Verbal reminders, 6. Reassurance as needed, 7. Resident teaching/education on safety concerns."

A Care Plan Worksheet for "Problem: Mood and Behavior Care Plan" indicated dates of 12/10/10, 12/14/10 and 1/6/11 with "Problem: Resident presents with primary diagnosis of dementia, depression, bipolar disorder, hx [history] of ETOH [alcohol] abuse, OCD [obsessive compulsive disorder), and may exhibit any or all of the following moods and behaviors." The list of behaviors included, but was not limited to, "...Wandering/Pacing within facility...Intruding into other's space." The Goal was "Episodes of moods and behaviors will be redirected and/or diffused daily thru [through] next review." Interventions included, but were not limited to,

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HILLCREST CENTRE FOR HEALTH AND REHABILITATION	203 SPARKS AVENUE JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 12 "...Bx [behavior contract] in place. Wanderguard bracelet - check placement & functioning q [every] shift." The Behavior Monthly Flow Record for December 2010 indicated the resident had behaviors including, but not limited to, continuous wandering on day shift on 12/18/10 and intruding into others' rooms and offices on day shift on 12/14, 12/18/10, 12/25/10, and 12/30/10. A psychiatric visit consult note dated 12/20/10 indicated, "Nsg [nursing] reports R [resident] having difficulty [symbol for with] adjustment - [symbol for not] sleeping at noc [night] - staying in lobby areas...." On 12/30/10 a physician's order was received for "May send to behavioral unit for evaluation & tx [treatment]." The History and Physical at the behavior center, dated 12/31/10 indicated, "History of Present Illness: ...More recently, he has been seen to be increasingly agitated and has been having behavioral problems. He has been stealing money and he has been intrusive and med [medication] seeking, and has been difficult to be redirected. He also smokes cigarettes and drinks diet coke constantly...." The resident was readmitted to the facility on 1/5/11. Documentation failed to indicate an Elopement Risk Assessment was completed upon the resident's return from the behavior center. Admission Orders and Plan of Care for	F 250		

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F 250	Continued From page 13 readmission included but were not limited to, "Treatments: Wanderguard to rt. wrist [checkmark] placement q shift" and "Activity level: Amb [ambulatory]." During interview on 1/11/11 at 3:05 p.m., the Director of Nursing (DoN) indicated she would need to check policy to see if a reassessment of Elopement Risk was required upon readmission from the behavior unit. During interview at this same time, the Social Worker and Social Services/Activities Consultant looked at each other and shook their heads "No" when the hourly monitoring of the resident indicated on the Elopement Risk Assessments dated 12/8 and 12/10/10 were discussed. On 1/12/11 at 2:55 p.m., documentation was provided by Nurse Consultant #1 related to the hourly monitoring. During interview at this time, she indicated the documentation was found in the Administrator's office. The documents were entitled, "Specialized Monitoring Every Hour Observation for Wandering Residents and Sexually Inappropriate Residents" The documents indicated Resident C was monitored hourly from 12/8/10 at 5:00 p.m. until 12/13 at 11:00 p.m. An unsigned and undated notation on the document dated 12/13/10 indicated, "Interdisciplinary team deemed no longer necessary for 1 [symbol for hour] checks d/t [due to] no exit leaving behavior." On 1/12/11 at 3:45 p.m. Nurse Consultant #1 provided copy of "Unit Manager Morning Meeting Summary" dated 12/13/10 which indicated, "[name of Resident C] - continuous questions, not sleeping well...up for IDT [interdisciplinary team] review hourly [checkmark]s, [name of Resident C] [symbol for no] attempts @ departure elopement d/c	F 250		

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F 250	Continued From page 14 [discontinue] please." Documentation failed to indicate the Elopement Risk Assessment and care plan were updated when the decision was made. The Behavior Monthly Flow Record for January 2011 indicated on 1/5/11 one episode of "Non-compliance [symbol for with] smoking/smoking R/T Bx" on evening shift. On 1/6/11 indicated one episode each of "Intruding into other's rooms/offices" and "Rep [repetitive] questions" on day shift. The record included no nurse's notes after 1/6/11 at 3:00 p.m., which indicated, "...Resident up ambulating per self...No s/s [signs and symptoms] of distress noted." Social services notes for 1/6/11 indicated, "Spoke with resident's brother/POA about res's continued behavior even after returning from behavior unit. Brother stated res knows better, I'll come talk to him. I don't know what else to do with him. Discussed options including the locked down men's unit in [name of another town] that would possibly be more appropriate setting for resident. Brother stated he wanted to talk to resident, and see if he could get behaviors under control, and if not he would pursue considering another facility." Documentation failed to indicate care plans were updated at this time. During interview on 1/12/11 at 3:15 p.m., Nurse Consultant #1 indicated she was trying to find the Social Worker to ask why an assessment of Risk for Elopement was not completed when the resident was readmitted to the facility on 1/5/11. On 1/12/11 at 3:25 p.m., the facility's Elopement	F 250		

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F 250	Continued From page 15 Risk Assessment Policy was provided by the Social Worker. Review of the policy indicated, "Policy: Assess residents for potential elopement. To assure that all residents are free from harm at all times. Procedures: 1. Identify residents at risk for elopement by completing the elopement risk assessment upon admission, quarterly and with significant changes in mental/psychosocial status. 2. Residents who are identified for possible elopement will immediately have interventions placed to prevent elopement...." During interview at that time, the Social Worker indicated the policy was a social services policy. This federal tag relates to Complaint IN00084571. 3.1-34(a)	F 250	**F272** *Requires the facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.*	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272		

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F 272	Continued From page 16 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the resident was assessed for risk of elopement as indicated in facility policy for 2 of 5 residents reviewed related to risk for elopement in a sample of 5 residents. (Residents C and B) Findings include: 1. The clinical record for Resident C was reviewed on 1/11/11 at 2:00 p.m. The record indicated the resident was admitted to the facility on 12/8/10 from another long term care facility. An Elopement Risk Assessment dated 12/8/10 indicated "Yes" answers to the following questions: "Is the resident cognitively impaired with poor decision making skills?, Does the resident have a diagnosis of dementia, OBS [organic brain syndrome] Alzheimers, delusions, hallucinations, anxiety, depression, or schizophrenia?, Does the resident ambulate independently, with or without the use of an assistive device?", and "Does the resident wander aimlessly?". Next to the question, "Is the	F 272	The facility will ensure this requirement is met through the following: 1. Resident B and C were not harmed. 2. All residents have the potential to be affected. 3. Elopement Risk Assessment policy reviewed and updated to include Elopement Binders (See Attachment D). All staff Elopement Risk Assessment Procedure on 1-28-11. 4. The Administrator or designee will utilize the Administrative Audit Tool (See Attachment E) to ensure Elopement Risk Assessments are being completed appropriately. Audits will be conducted 5 days a week times 4 weeks, then weekly times 4 weeks, then every 2 weeks times 2 months, then quarterly times 2 quarters. The audits will be reviewed during the	

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F 272	Continued From page 17 wandering behavior a pattern or routine tied to resident's past? was written: "Possibly." Next to the question, "Has the resident been recently admitted or readmitted (within past 30 days) and not accepting of the situation?" was written: "New admit." On the reverse side of the assessment in the section for "Summary of Assessment" was marked with a checkmark: "Resident at risk for elopement, as evidenced by: dementia, depression, hx [history] of wandering aimlessly, ambulates independently. Next to "Appropriate interventions have been:" was a checkmark next to "Initiated." Interventions selected for initiation were: "1. Personal safety alarm devices, 2. Exit and stairwell alarms, and 4. Frequent monitoring. Check every [handwritten in blank space was the word] hour." The assessment was signed by a nurse. An Elopement Risk Assessment dated 12/10/10 indicated a check mark next to "Yes" answers to the following questions: "Is the resident cognitively impaired with poor decision making skills?, Does the resident have a diagnosis of dementia, OBS [organic brain syndrome] Alzheimers, delusions, hallucinations, anxiety, depression, or schizophrenia?, Does the resident ambulate independently, with or without the use of an assistive device?", and "Does the resident wander aimlessly?". Next to the question, "Is the wandering behavior a pattern or routine tied to resident's past?" where "Possibly" was written was a checkmark. Next to the question, "Has the resident been recently admitted or readmitted (within past 30 days) and not accepting of the situation?" where "New admit" was written was a checkmark. On the reverse side of the assessment in the section for "Summary of Assessment" was marked with a checkmark:	F 272	facility's quarterly quality assurance meeting and issues will be addressed and the above plan will be altered accordingly. 5. The above plan of correction will be completed on or before February 11, 2011.	

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F 272	Continued From page 18	F 272		

"Resident at risk for elopement, as evidenced by: wanders/pacing, [arrow pointing down] cognition, ambulates independently." dementia, depression, hx [history] of wandering aimlessly, ambulates independently. Next to "Appropriate interventions have been:" was a checkmark next to "reviewed." Interventions selected for review were: "4. Frequent monitoring. Check every [handwritten] hour. 5. Keep behavior logs, 8. Recreational activities, 9. Music, 13. Staff aware of wander risk, 14. Other: [handwritten] Wanderguard." The assessment was signed by the social worker.

On 1/12/11 at 2:55 p.m., documentation was provided by Nurse Consultant #1 related to the hourly monitoring. During interview at this time, she indicated the documentation was found in the Administrator's office. The documents were entitled, "Specialized Monitoring Every Hour Observation for Wandering Residents and Sexually Inappropriate Residents" The documents indicated Resident C was monitored hourly from 12/8/10 at 5:00 p.m. until 12/13 at 11:00 p.m. An unsigned and undated notation on the document dated 12/13/10 indicated, "Interdisciplinary team deemed no longer necessary for 1 [symbol for hour] checks d/t [due to] no exit leaving behavior." On 1/12/11 at 3:45 p.m. Nurse Consultant #1 provided copy of "Unit Manager Morning Meeting Summary" dated 12/13/10 which indicated, "[name of Resident C] - continuous questions, not sleeping well...up for IDT [interdisciplinary team] review hourly [checkmark]s, [name of Resident C] [symbol for no] attempts @ departure elopement d/c [discontinue] please."

Documentation failed to indicate the Elopement Risk Assessment and plan were updated when

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F 272	Continued From page 19 the decision was made on 12/13/10 to discontinue the hourly monitoring. On 12/30/10 a physician's order was received for "May send to behavioral unit for evaluation & tx [treatment]." The History and Physical at the behavior center, dated 12/31/10 indicated, "History of Present Illness: ...More recently, he has been seen to be increasingly agitated and has been having behavioral problems. He has been stealing money and he has been intrusive and med [medication] seeking, and has been difficult to be redirected. He also smokes cigarettes and drinks diet coke constantly...." The resident was readmitted to the facility on 1/5/11. Documentation failed to indicate an Elopement Risk Assessment was completed upon the resident's return from the behavior center. During interview completed on 1/11/11 at 12:45 p.m., the facility's Nurse Consultant #1 indicated the resident eloped from the facility on 1/8/11. During interview on 1/12/11 at 3:15 p.m., Nurse Consultant #1 indicated she was trying to find the Social Worker to ask why an assessment of risk for elopement was not completed when the resident was readmitted to the facility on 1/5/11. On 1/12/11 at 3:25 p.m., the facility's Elopement Risk Assessment Policy was provided by the Social Worker. Review of the policy indicated, "Policy: Assess residents for potential elopement. To assure that all residents are free from harm at	F 272		

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F 272	Continued From page 20	F 272		

all times. Procedures: 1. Identify residents at risk for elopement by completing the elopement risk assessment upon admission, quarterly and with significant changes in mental/psychosocial status. 2. Residents who are identified for possible elopement will immediately have interventions placed to prevent elopement...."

2. The clinical record for Resident B was reviewed on 1/12/11 at 2:55 p.m. The record indicated the resident was admitted on 12/22/10.

An Elopement Risk Assessment dated 12/23/10 indicated "Yes" to the following questions: "Is the resident cognitively impaired with poor decision making skills? Does the resident have a diagnosis of dementia, OBS [organic brain syndrome], Alzheimers, delusions, hallucinations, anxiety, depression, or schizophrenia?, and Does the resident have any hearing, vision, or communication problems? All other questions were answered "No." The "Summary of Assessment" indicated, "Resident is not at risk for elopement at this time" and "Diagnosis: dementia/HOH [hard of hearing]" and was signed by a nurse.

An Elopement Risk Assessment dated 1/8/11, indicated "Yes" to the following questions: "Is the resident cognitively impaired with poor decision making skills? Does the resident have a diagnosis of dementia, OBS [organic brain syndrome] Alzheimers, delusions, hallucinations, anxiety, depression, or schizophrenia?, Does the resident have any hearing, vision, or communication problems?, and Has resident been recently admitted or re-admitted (within past 30 days) and not accepting the situation?" All other questions were answered "No." The

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F 272	Continued From page 21 "Summary of Assessment" indicated, "Resident is at risk for elopement, as evidenced by: new environment, dementia" "Appropriate interventions have been:" was checkmarked for "Reviewed." Also checkmarked was "Plan of Care updated." The intervention was: "14. Wanderguard." The Medication Administration Record for December 2010 indicated the resident had a Wanderguard to the left wrist which was checked each shift for placement and function on 12/23/10 and all dates afterwards. During interview on 1/12/11 at 4:00 p.m., the Social Worker indicated Resident B was not deemed an elopement risk upon assessment, but the family requested she have a Wanderguard placed, due to a history of wandering, and a physician's order was obtained and care was planned related to the history of wandering at that time. The Social Worker indicated she had not completed another Elopement Risk Assessment at that time but should have. This federal tag relates to Complaint IN00084571. 3.1-31(a)	F 272	**F280** *Resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.*	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280	The facility will ensure this requirement is met through the following: 1. Resident C was not harmed.	

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F 280	Continued From page 22 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure care plans related to smoking and elopement risk were revised with new interventions as the resident's needs changed. The deficient practice affected 1 of 1 resident reviewed related to a smoking agreement and 1 of 5 residents reviewed related to elopement risk in a sample of 5. (Resident C) Findings include: The clinical record for Resident C was reviewed on 1/11/11 at 2:00 p.m. The record indicated the resident was admitted on 12/8/10. Diagnoses included, but were not limited to, dementia, depression, obsessive compulsive disorder, bipolar disorder, and history of tobacco and alcohol use. 1A. The Social History and Psychosocial Assessment dated 12/8/10, indicated in the section for "Social Involvement/Interests/Hobbies, How did resident spend their days? Describe	F 280	2. All residents have the potential to be affected. 3. Care Plan Development and Review Procedure reviewed with no changes made (See Attachments F). Interdepartmental Team in-serviced on the above policy on 1-28-11. 4. The Administrator or designee will utilize the Administrative Audit Tool (See Attachment E) 5 days a week times 4 weeks, then weekly times 4 weeks, then every 2 weeks times 2 months, then quarterly times 2 quarters The audits will be reviewed during the facility's quarterly quality assurance meeting and issues will be addressed and the above plan will be altered accordingly. 5. The above plan of correction will be completed on or before February 11, 2011.	

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F 280	Continued From page 23 past customary routines: ...smoke...." The Initial Social Services Assessment dated 12/10/10 indicated the resident's mood indicators included, but were not limited to, "Repetitive questions re: smoking times...." The facility policy titled "Hillcrest Centre Resident Smoking Policy Updated 7-10-08" was included in the resident's record and was signed by the resident on 12/10/10. "Safe Smoking," item #9 indicated, "A resident may smoke however many cigarettes he or she are [sic] capable of smoking within the allotted smoking time (2, 3, etc.). If the resident has a lit cigarette at the end of the allotted smoking time, the cigarette must be put out." A Smoking Assessment dated 12/9/10 with review date of 12/16/10 indicated, "Rep [repetitive] questions r/t [related to] smoke time, Hx [history] of unsafe smoking 12/15/10." Nurse's Note dated 12/16/10 at 1:10 p.m. indicated, "...Resident continues to badger staff regarding...smoke breaks." A Behavioral Contract signed by the resident and Social Worker dated 12/16/10, included, but was not limited to, related to behaviors, "Non-compliance with smoking policy," and "I have agreed to 1. Smoke at designated times & locations, per policy/signed...." The document indicated, "I am willing to work with the staff to improve on them [behaviors]. The staff will provide me with 1. Problem solving techniques, 2. Solutions to resolve these issues, 3. Praise, 4. Support, 5. Verbal reminders, 6. Reassurance as needed, 7. Resident teaching/education on	F 280		

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F 280	Continued From page 24 safety concerns." A Social Service Progress Note dated 12/16/10 (no time indicated) indicated, "Follow-up MDS [Minimum Data Set] [assessment] interview. Res. is a tobacco user. When asked if he would like information on quitting res responded, No, I've smoked for as long as I can remember. Res's wishes to be honored. Res. placed on bx [behavior] contract, family aware. Will continue to monitor." The record included a Careplan Worksheet with "Problem: Non-Compliance with Smoking Policy," dated 12/16/10 and 1/6/11. The goal indicated, "Compliance with smoking policy thru [through] next review." Interventions included, but were not limited to, "Remind res [resident] of agreement w/[with] brother/POA [power of attorney] of 1 cigarette per break prn [as needed]." Documentation failed to indicate details of the resident's agreement with the brother to smoke only one cigarette at each smoke break or a plan if the resident wished to smoke more cigarettes. The admission Minimum Data Set assessment dated 12/16/10 indicated in the section for Behavioral Symptoms: "Supporting Documentation:" "Res [resident] has become verbally aggressive with staff, unprovoked with purpose r/t [related to] smoke breaks and smoking policy." The "Analysis of Findings" indicated, "Res. has become aggressive during smoke breaks...." "Care Plan Considerations" indicated, "Careplans will be developed per company policy to address physical and psychosocial well-being."	F 280		

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F 280	Continued From page 25 Mood and Behavior Communication Memos indicated the following in the section titled, "Provide detailed information on the mood and/or behavior that the resident was experiencing:" 12/9/10 (time not indicated): "Resident continually asking when next smoke time is....At times showing impatience with staff when wants not met immediately." 12/16/10 at 5:15 p.m., "I had taken residents out to smoke when 15 min. [minutes] had passed [name of Resident C] ask [sic] for a cig [cigarette], and when I told him no we had to go back in he told me he won't eat without a cig, and he was going to a cig [sic] from me if I didn't give him one." The possible trigger of the behavior indicated, "Wanted a cigarette." 12/16/10 at 8:00 p.m., "Resident went to shower room to use the B/R [bathroom] because was out of order - activity director walked by shower room & smelled smoke - res. already went back to his room across the hall. When confronted, he admitted to smoking in that shower room & gave me his cigarettes & lighter. Explained the importance of not smoking in the building & observing smoke times, stated understanding." The possible trigger for the behavior indicated, "Wanted to go smoke but it wasn't smoke time yet." 12/17/10 at 6:00 p.m., "Took him out to smoke, and he didn't want his smokes, wanted other residents cigs, when I told him here was his smokes, and he couldn't have the other residents. He then got into my face, and told me he was going to take the cigs if he has to. I had someone go get the nurse, when the nurse [name] came	F 280		

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F 280	Continued From page 26 out she told him he couldn't have them, he then set back down. Telling me I will get those cigs. Then I saw him take cigs out of his pockets. When nurse checked she couldn't find them." The possible trigger of the behavior indicated, "Wanting other cigs." A psychiatric consult visit note dated 12/20/10 indicated, "...Cont. [continues] fixated on smoking break, cigs & money needs." Mood and Behavior Communication Memos indicated the following in the section titled, "Provide detailed information on the mood and/or behavior that the resident was experiencing:" 12/28/10 at 6:05 a.m., "It was 6:05 AM I told (names of three residents including Resident C) that we didn't have time to smoke the third cigarette. [Names of two residents] gave me back the cigarettes and [name of Resident C] lite [sic] his cigarette off another one he had and wouldn't put it out and he kept smoking and I repatly [sic] to him that he just kept smoking." The possible trigger of the behavior indicated, "Unknown." On 12/30/10 a physician's order was received for "May send to behavioral unit for evaluation & tx [treatment]." The History and Physical at the behavior center, dated 12/31/10 indicated, "History of Present Illness: ...More recently, he has been seen to be increasingly agitated and has been having behavioral problems. He has been stealing money and he has been intrusive and med [medication] seeking, and has been difficult to be redirected. He also smokes cigarettes and drinks diet coke constantly...."	F 280		

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F 280	Continued From page 27 The resident was readmitted to the facility on 1/5/11. Mood and Behavior Communication Memos indicated the following in the section titled, "Provide detailed information on the mood and/or behavior that the resident was experiencing:" 1/5/11 at 6:00 p.m., "CNA took smokers at [sic] when they all got outside [name of Resident C] was telling CNA he got to smoke 3 cigs when CNA told him he can only have 1. He got mad and started yelling (I get 3 cigs) CNA told him her boss had a note on the smoke box, and read it to him, and told him she had to do what she told. Resident wouldn't hear what she was saying. [sic]" A Care Plan Worksheet for "Problem: Mood and Behavior Care Plan" indicated dates of 12/10/10, 12/14/10 and 1/6/11 with "Problem: Resident presents with primary diagnosis of dementia, depression, bipolar disorder, hx [history] of ETOH [alcohol] abuse, OCD [obsessive compulsive disorder), and may exhibit any or all of the following moods and behaviors." The list of behaviors included, but was not limited to, "Rep. questions - i.e. smoke breaks....Non-compliance [symbol for with] smoking policy." The Goal was "Episodes of moods and behaviors will be redirected and/or diffused daily thru [through] next review." Interventions included, but were not limited to, "Bx [behavior contract] in place." Documentation failed to indicate the plan had been updated with specific interventions to address the problems indicated during smoke breaks. During interview completed on 1/11/11 at 12:45	F 280		

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p.m., the facility's Nurse Consultant #1 indicated the resident eloped from the facility on 1/8/11. She indicated that during the investigation into the elopement, another resident told her Resident C said "he was going to [name of city across river in another state] to smoke what he wanted to smoke." The Nurse Consultant also indicated she was told by the facility's Admissions Coordinator that when she visited Resident C in the acute care hospital after the elopement, the resident indicated he was getting back at his brother related to the decrease in his cigarettes.

During interview with the Social Worker and Social Services/Activities Consultant on 1/11/11 at 3:05 p.m., the Consultant indicated the resident had made a deal with his brother to smoke only one cigarette at each smoke break, and the facility had encouraged the resident to smoke just one cigarette.

During interview completed 1/12/11 at 4:00 p.m. with Nurse Consultant #1 and the Social Worker, the Nurse Consultant indicated she thought the resident's brother and Power of Attorney wanted the resident to smoke only one cigarette due to money issues. She indicated the staff would give the resident more cigarettes if he asked for them, since they were his, and staff wanted to collect money to buy him cigarettes. She also indicated the facility was concerned about infringing on the resident's rights if he weren't allowed to smoke his cigarettes. The Social Worker indicated no specific interventions had been planned to assist the staff to deal with the one-cigarette agreement, and no family meeting or care planning had taken place related to the one-cigarette agreement.

1B. An Elopement Risk Assessment dated

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12/8/10 indicated "Yes" answers to the following questions: "Is the resident cognitively impaired with poor decision making skills?, Does the resident have a diagnosis of dementia, OBS [organic brain syndrome] Alzheimers, delusions, hallucinations, anxiety, depression, or schizophrenia?, Does the resident ambulate independently, with or without the use of an assistive device?", and "Does the resident wander aimlessly?". Next to the question, "Is the wandering behavior a pattern or routine tied to resident's past? was written: "Possibly." Next to the question, "Has the resident been recently admitted or readmitted (within past 30 days) and not accepting of the situation?" was written: "New admit." On the reverse side of the assessment in the section for "Summary of Assessment" was marked with a checkmark: "Resident at risk for elopement, as evidenced by: dementia, depression, hx [history] of wandering aimlessly, ambulates independently. Next to "Appropriate interventions have been:" was a checkmark next to "Initiated." Interventions selected for initiation were: "1. Personal safety alarm devices, 2. Exit and stairwell alarms, and 4. Frequent monitoring. Check every [handwritten in blank space was the word] hour." The assessment was signed by a nurse.

A Care Plan Worksheet indicated a problem dated 12/8/10 for "Resident has been found to be at risk for elopement d/t [due to] depression, dementia, aimlessly wandering." The goal was, "Resident will not leave the facility unattended thru [through] the next review." Interventions included, "Complete elopement risk assessment. Use Redirection, distraction and re-orientation when resident attempts to exit bldg [building]. Follow facility policy and procedures. Encourage

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participation in activities of choice and interest. Ensure all basic needs have been met. Observe for s/s [signs and symptoms] of depression. Mental health services as needed or ordered." Documentation failed to indicate the care plan was updated after 12/8/10.

Admission Orders and Plan of Care dated 12/8/10, signed but not dated by the physician, included, but were not limited to, "Wanderguard [Departure Alert System] rt. [right] wrist - check placement q [every] shift." The nurse signed "Above orders verified per telephone with physician" with the date written is as: "12/[blank space]/10."

An Elopement Risk Assessment dated 12/10/10 indicated a check mark next to "Yes" answers to the following questions: "Is the resident cognitively impaired with poor decision making skills?, Does the resident have a diagnosis of dementia, OBS [organic brain syndrome] Alzheimers, delusions, hallucinations, anxiety, depression, or schizophrenia?, Does the resident ambulate independently, with or without the use of an assistive device?", and "Does the resident wander aimlessly?". Next to the question, "Is the wandering behavior a pattern or routine tied to resident's past?" where "Possibly" was written was a checkmark. Next to the question, "Has the resident been recently admitted or readmitted (within past 30 days) and not accepting of the situation?" where "New admit" was written was a checkmark. On the reverse side of the assessment in the section for "Summary of Assessment" was marked with a checkmark: "Resident at risk for elopement, as evidenced by: wanders/pacing, [arrow pointing down] cognition, ambulates independently." dementia, depression,

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hx [history] of wandering aimlessly, ambulates independently. Next to "Appropriate interventions have been:" was a checkmark next to "reviewed." Interventions selected for review were: "4. Frequent monitoring. Check every [handwritten] hour. 5. Keep behavior logs, 8. Recreational activities, 9. Music, 13. Staff aware of wander risk, 14. Other: [handwritten] Wanderguard." The assessment was signed by the social worker.

During interview on 1/11/11 at 3:05 p.m., the Social Worker and Social Services/Activities Consultant discussed how the decision was made to use the Wanderguard system for this resident on 12/8/10. The Social Services/Activities Consultant indicated that on the day the resident moved into the facility, she was the Administrator at the facility and saw from her office window that the resident went out to his brother's truck as the brother was unloading the resident's belongings to bring into the facility. She indicated she felt the resident needed a Wanderguard at that time and requested it be used, and that the resident would be monitored for a quarter. She indicated she did not document the information.

On 1/12/11 at 2:55 p.m., documentation was provided by Nurse Consultant #1 related to the hourly monitoring. During interview at this time, she indicated the documentation was found in the Administrator's office. The documents were entitled, "Specialized Monitoring Every Hour Observation for Wandering Residents and Sexually Inappropriate Residents" The documents indicated Resident C was monitored hourly from 12/8/10 at 5:00 p.m. until 12/13 at 11:00 p.m. An unsigned and undated notation on the document dated 12/13/10 indicated, "Interdisciplinary team deemed no longer

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necessary for 1 [symbol for hour] checks d/t [due to] no exit leaving behavior." On 1/12/11 at 3:45 p.m. Nurse Consultant #1 provided copy of "Unit Manager Morning Meeting Summary" dated 12/13/10 which indicated, "[name of Resident C] - continuous questions, not sleeping well...up for IDT [interdisciplinary team] review hourly [checkmark]s, [name of Resident C] [symbol for no] attempts @ departure elopement d/c [discontinue] please." Documentation failed to indicate the Elopement Risk Assessment and care plan were updated when the decision was made.

The admission Minimum Data Set assessment dated 12/16/10 indicated the resident did not have wandering behaviors during the assessment period.

A Behavioral Contract signed by the resident and Social Worker dated 12/16/10, included, but was not limited to, related to behaviors, "Wandering/Intrusive/Elopement," and "I have agreed to "...2. Not to leave facility without signing out with my responsible party. 3. Not to enter other's rooms, office...." The document indicated, "I am willing to work with the staff to improve on them [behaviors]. The staff will provide me with 1. Problem solving techniques, 2. Solutions to resolve these issues, 3. Praise, 4. Support, 5. Verbal reminders, 6. Reassurance as needed, 7. Resident teaching/education on safety concerns."

A Care Plan Worksheet for "Problem: Mood and Behavior Care Plan" indicated dates of 12/10/10, 12/14/10 and 1/6/11 with "Problem: Resident presents with primary diagnosis of dementia, depression, bipolar disorder, hx [history] of ETOH [alcohol] abuse, OCD [obsessive compulsive

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disorder), and may exhibit any or all of the following moods and behaviors." The list of behaviors included, but was not limited to, "...Wandering/Pacing within facility...Intruding into other's space." The Goal was "Episodes of moods and behaviors will be redirected and/or diffused daily thru [through] next review." Interventions included, but were not limited to, "...Bx [behavior contract] in place. Wanderguard bracelet - check placement & functioning q [every] shift."

The Behavior Monthly Flow Record for December 2010 indicated the resident had behaviors including, but not limited to, continuous wandering on day shift on 12/18/10 and intruding into others' rooms and offices on day shift on 12/14, 12/18/10, 12/25/10, and 12/30/10.

A psychiatric visit consult note dated 12/20/10 indicated, "Nsg [nursing] reports R [resident] having difficulty [symbol for with] adjustment - [symbol for not] sleeping at noc [night] - staying in lobby areas...."

On 12/30/10 a physician's order was received for "May send to behavioral unit for evaluation & tx [treatment]."

The History and Physical at the behavior center, dated 12/31/10 indicated, "History of Present Illness: ...More recently, he has been seen to be increasingly agitated and has been having behavioral problems. He has been stealing money and he has been intrusive and med [medication] seeking, and has been difficult to be redirected. He also smokes cigarettes and drinks diet coke constantly...."

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F 280	Continued From page 34 The resident was readmitted to the facility on 1/5/11. Documentation failed to indicate an Elopement Risk Assessment was completed upon the resident's return from the behavior center. Admission Orders and Plan of Care for readmission included, but were not limited to, "Treatments: Wanderguard to rt. wrist [checkmark] placement q shift" and "Activity level: Amb [ambulatory]." The Behavior Monthly Flow Record for January 2011 indicated on 1/5/11 one episode of "Non-compliance [symbol for with] smoking/smoking R/T Bx" on evening shift. On 1/6/11 indicated one episode each of "Intruding into other's rooms/offices" and "Rep [repetitive] questions" on day shift. The record included no nurse's notes after 1/6/11 at 3:00 p.m. The notes for 1/6/11 at 3:00 p.m. indicated, "...Resident up ambulating per self...No s/s [signs and symptoms] of distress noted." Social services notes for 1/6/11 indicated, "Spoke with resident's brother/POA about res's continued behavior even after returning from behavior unit. Brother stated res knows better, I'll come talk to him. I don't know what else to do with him. Discussed options including the locked down men's unit in [name of another town] that would possibly be more appropriate setting for resident. Brother stated he wanted to talk to resident, and see if he could get behaviors under control, and if not he would pursue considering another facility." Documentation failed to indicate care plans were updated at this time.	F 280		

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F 280	Continued From page 35 During interview on 1/12/11 at 3:15 p.m., Nurse Consultant #1 indicated she was trying to find the Social Worker to ask why an assessment of Risk for Elopement was not completed when the resident was readmitted to the facility on 1/5/11. On 1/12/11 at 3:25 p.m., the facility's Elopement Risk Assessment Policy was provided by the Social Worker. Review of the policy indicated, "Policy: Assess residents for potential elopement. To assure that all residents are free from harm at all times. Procedures: 1. Identify residents at risk for elopement by completing the elopement risk assessment upon admission, quarterly and with significant changes in mental/psychosocial status. 2. Residents who are identified for possible elopement will immediately have interventions placed to prevent elopement...." During interview at that time, the Social Worker indicated the policy was a social services policy. This federal tag relates to Complaint IN00084571. 3.1-35(d)(2)(B)	F 280	**F323** *Requires the facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.* The facility will ensure this requirement is met through the following: 1. Resident C was hospitalized. All door alarms were checked for functionality. Keypads, Maglocks, and Exit Stoppers were ordered to replace the "Radio Shack" alarms in facility on 1-10-11 and 1-11-11. Items were delivered on 1-12-11 and installation process initiated. 2. All residents have the potential to be affected. Maintenance or designee will check all alarms daily.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		

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F 323	Continued From page 36 A. Based on record review and interview, the facility failed to ensure a resident at risk for elopement was assessed, care was planned, and the resident was supervised to prevent elopement for 1 of 5 residents reviewed related to risk for elopement in a sample of 5. (Resident C) Resident C eloped from the facility and was found non-responsive on public transportation in an adjoining city across a river. The resident required emergency medical services and was hospitalized with diagnoses including, but not limited to, alcohol intoxication. The resident required ventilator support during hospitalization. B. Based on observation, record review, and interview, the facility failed to ensure door alarms used to alert staff to residents exiting the facility without supervision were functioning. The deficient practice had the potential to affect 16 of 16 residents identified by the facility at risk for elopement. Findings include: A. An interview was completed on 1/11/11 at 12:45 p.m. with the facility's Nurse Consultant #1 and Nurse Consultant #2, the Administrator, and the Director of Nursing. During the interview, Nurse Consultant #1 provided a binder containing documentation related to the elopement of Resident C on 1/8/11. Information in the binder indicated on 1/8/11, Resident C participated in the facility's 6:00 a.m. smoke break, and at 10:00 a.m., Resident C could not be located to receive medications. Facility staff implemented the facility elopement procedure.	F 323	3. Elopement Risk Assessment Procedure and Care Plan Development and Review Procedure reviewed and the Elopement Risk Assessment Procedure updated (See Attachment D and F). Daily Checklist for Wanderguards and Other Alarms reviewed and updated (See Attachment G). All staff in-serviced on the Elopement Risk Assessment Procedure and the Interdisciplinary Team in-serviced on the Care Plan Development and Review Procedure, Maintenance and Nurse Management staff in-serviced on Daily Checklist for Wanderguards and Other Alarms on 1-28-11. 4. The Administrator or designee will complete the Administrative Audit Tool 5 days a week times 4 weeks, then weekly times 4	

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F 323	Continued From page 37 Also included in the binder was a plastic bag containing a Wanderguard bracelet with the wristband cut, and also a nail clipper. During the interview, Nurse Consultant #1 indicated the items were found in the resident's drawer in his room during investigation into the elopement. She indicated the resident had apparently cut the wristband with the nail clippers. She also indicated it was unknown which door the resident used to leave the facility. Written statements by staff on duty before and after the elopement indicated the following: RN #4, "On the night of 1/7/11, I performed 15 minute checks on [name of Resident C]....He was given his a.m. [morning] meds [medications] at around 6:00 a.m., and at this time I noted a Wanderguard on his wrist. While taking his meds [medications] he did state that he did not 'like it here.'" LPN #5, "...I went to his room @ 10 AM [a.m.] and attempted to give him his medication as ordered. He wasn't there, so I went to the smokers lounge and he wasn't there. I spoke [symbol for with] week-end supervisor and let her know his breakfast tray was there and he hadn't touched it. I was attempting to locate him and he wasn't anywhere so far that I had looked. As the events unfolded he had cut his safety band off and left the facility...." During telephone interview completed on 1/11/11 at 10:45 p.m., RN #4 indicated she checked the resident every 15 minutes (on the night of 1/7/11 -1/8/11) since he had been out to the behavior center. She indicated this wasn't part of the plan for Resident C, but she always watched residents	F 323	weeks, then every 2 weeks times 2 months, then quarterly times 2 quarters (See Attachment E). The audits will be reviewed during the facility's quarterly quality assurance meeting and issues will be addressed and the above plan will be altered accordingly. 5. The above plan of correction will be completed on or before February 11, 2011.	

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closely if they had a problem with behaviors. She indicated she had not seen the behavior but heard that Resident C obtained money from other residents. She indicated the resident had slept until about 2:30 a.m. and then was up sitting at the door to the smoking area or in the lounge the remainder of the night. She indicated she saw the resident about 6:45 a.m. after he went out to smoke and then returned to his room.

Documentation failed to indicate the every 15 minute checks or that the resident was seen between 6:45 a.m. and 10:00 a.m. on 1/8/11.

Emergency medical services records in the binder indicated assessment of the resident was initiated on 1/8/11 (earliest legible time 9:39 a.m.), and the resident was received by the emergency room nurse on 1/8/11 at 10:37 a.m. Narrative information on the emergency medical services report indicated, "Crew called for unresponsive. Arrived to find [age] on [name of local public transportation company] bus unresponsive. Bystanders stated that pt [patient] had been drinking and suddenly became unresponsive. Pupils dilated and non reactive...." The report indicated further assessment of the resident, an intravenous line was placed, Narcan was administered, and the resident was started on oxygen at 15 liters per minute by rebreather mask and transported to the hospital emergency room.

Hospital records in the binder indicated the resident was transferred from the emergency room to a hospital intensive care unit on 1/11/11 at 12:15 p.m. The history and physical note dated 1/8/11 at 9:40 p.m., indicated, "...in the ER [emergency room]...He was nasally intubated....Despite not being sedated, he

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remained nonresponsive more than 3 hours after intubation, so we called for vent [ventilator] management." The assessment and plan indicated, "...Will admit and treat....CNS [central nervous system]: alcohol intoxication: no sedation. CPAP [continuous positive airway pressure] trial when he wakes up, followed by spontaneous breathing trial with weaning parameters. Expect will be able to extubate him tonight or tomorrow morning..."

The clinical record for Resident C was provided and reviewed on 1/11/11 at 2:00 p.m. The record indicated the resident was admitted to the facility on 12/8/10 from another long term care facility.

An Elopement Risk Assessment dated 12/8/10 indicated "Yes" answers to the following questions: "Is the resident cognitively impaired with poor decision making skills?, Does the resident have a diagnosis of dementia, OBS [organic brain syndrome] Alzheimers, delusions, hallucinations, anxiety, depression, or schizophrenia?, Does the resident ambulate independently, with or without the use of an assistive device?", and "Does the resident wander aimlessly?". Next to the question, "Is the wandering behavior a pattern or routine tied to resident's past? was written: "Possibly." Next to the question, "Has the resident been recently admitted or readmitted (within past 30 days) and not accepting of the situation?" was written: "New admit." On the reverse side of the assessment in the section for "Summary of Assessment" was marked with a checkmark: "Resident at risk for elopement, as evidenced by: dementia, depression, hx [history] of wandering aimlessly, ambulates independently. Next to "Appropriate interventions have been:" was a checkmark next

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to "Initiated." Interventions selected for initiation were: "1. Personal safety alarm devices, 2. Exit and stairwell alarms, and 4. Frequent monitoring. Check every [handwritten in blank space was the word] hour." The assessment was signed by a nurse.

Admission Orders and Plan of Care dated 12/8/10, signed but not dated by the physician, included, but were not limited to, "Wanderguard [Departure Alert System] rt. [right] wrist - check placement q [every] shift." The nurse signed "Above orders verified per telephone with physician" with the date written is as: "12/[blank space]/10."

An Elopement Risk Assessment dated 12/10/10 indicated a check mark next to "Yes" answers to the following questions: "Is the resident cognitively impaired with poor decision making skills?, Does the resident have a diagnosis of dementia, OBS [organic brain syndrome] Alzheimers, delusions, hallucinations, anxiety, depression, or schizophrenia?, Does the resident ambulate independently, with or without the use of an assistive device?", and "Does the resident wander aimlessly?". Next to the question, "Is the wandering behavior a pattern or routine tied to resident's past?" where "Possibly" was written was a checkmark. Next to the question, "Has the resident been recently admitted or readmitted (within past 30 days) and not accepting of the situation?" where "New admit" was written was a checkmark. On the reverse side of the assessment in the section for "Summary of Assessment" was marked with a checkmark: "Resident at risk for elopement, as evidenced by: wanders/pacing, [arrow pointing down] cognition, ambulates independently." dementia, depression,

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hx [history] of wandering aimlessly, ambulates independently. Next to "Appropriate interventions have been:" was a checkmark next to "reviewed." Interventions selected for review were: "4. Frequent monitoring. Check every [handwritten] hour. 5. Keep behavior logs, 8. Recreational activities, 9. Music, 13. Staff aware of wander risk, 14. Other: [handwritten] Wanderguard." The assessment was signed by the social worker.

Documentation in the record failed to indicate the hourly monitoring of the resident was completed.

During interview on 1/11/11 at 3:05 p.m., the Social Worker and Social Services/Activities Consultant discussed how the decision was made to use the Wanderguard system for this resident on 12/8/10. The Social Services/Activities Consultant indicated that on the day the resident moved into the facility, she was the Administrator at the facility and saw from her office window that the resident went out to his brother's truck as the brother was unloading the resident's belongings to bring into the facility. She indicated she felt the resident needed a Wanderguard at that time and requested it be used, and that the resident would be monitored for a quarter. She indicated she did not document the information.

The admission Minimum Data Set assessment dated 12/16/10 indicated the resident did not have wandering behaviors during the assessment period.

A Care Plan Worksheet indicated a problem dated 12/8/10 for "Resident has been found to be at risk for elopement d/t [due to] depression, dementia, aimlessly wandering." The goal was, "Resident will not leave the facility unattended

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thru [through] the next review." Interventions included, "Complete elopement risk assessment. Use Redirection, distraction and re-orientation when resident attempts to exit bldg [building]. Follow facility policy and procedures. Encourage participation in activities of choice and interest. Ensure all basic needs have been met. Observe for s/s [signs and symptoms] of depression. Mental health services as needed or ordered." Documentation failed to indicate the care plan was updated after 12/8/10.

A Behavioral Contract signed by the resident and Social Worker dated 12/16/10, included, but was not limited to, related to behaviors, "Wandering/Intrusive/Elopement," and "I have agreed to "...2. Not to leave facility without signing out with my responsible party. 3. Not to enter other's rooms, office...." The document indicated, "I am willing to work with the staff to improve on them [behaviors]. The staff will provide me with 1. Problem solving techniques, 2. Solutions to resolve these issues, 3. Praise, 4. Support, 5. Verbal reminders, 6. Reassurance as needed, 7. Resident teaching/education on safety concerns."

A Care Plan Worksheet for "Problem: Mood and Behavior Care Plan" indicated dates of 12/10/10, 12/14/10 and 1/6/11 with "Problem: Resident presents with primary diagnosis of dementia, depression, bipolar disorder, hx [history] of ETOH [alcohol] abuse, OCD [obsessive compulsive disorder), and may exhibit any or all of the following moods and behaviors." The list of behaviors included, but was not limited to, "...Wandering/Pacing within facility...Intruding into other's space." The Goal was "Episodes of moods and behaviors will be redirected and/or diffused daily thru [through] next review."

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F 323	Continued From page 43 Interventions included, but were not limited to, "...Bx [behavior contract] in place. Wanderguard bracelet - check placement & functioning q [every] shift." The Behavior Monthly Flow Record for December 2010 indicated the resident had behaviors including, but not limited to, continuous wandering on day shift on 12/18/10 and intruding into others' rooms and offices on day shift on 12/14, 12/18/10, 12/25/10, and 12/30/10. A psychiatric visit consult note dated 12/20/10 indicated, "Nsg [nursing] reports R [resident] having difficulty [symbol for with] adjustment - [symbol for not] sleeping at noc [night] - staying in lobby areas...." On 12/30/10 a physician's order was received for "May send to behavioral unit for evaluation & tx [treatment]." The History and Physical at the behavior center, dated 12/31/10 indicated, "History of Present Illness: ...More recently, he has been seen to be increasingly agitated and has been having behavioral problems. He has been stealing money and he has been intrusive and med [medication] seeking, and has been difficult to be redirected. He also smokes cigarettes and drinks diet coke constantly...." The resident was readmitted to the facility on 1/5/11. Documentation failed to indicate an Elopement Risk Assessment was completed upon the resident's return from the behavior center.	F 323		

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Admission Orders and Plan of Care for readmission included, but were not limited to, "Treatments: Wanderguard to rt. wrist [checkmark] placement q shift" and "Activity level: Amb [ambulatory]."

During interview on 1/11/11 at 3:05 p.m., the Director of Nursing (DoN) indicated she would need to check policy to see if a reassessment of Elopement Risk was required upon readmission from the behavior unit. During interview at this same time, the Social Worker and Social Services/Activities Consultant looked at each other and shook their heads "No" when the hourly monitoring of the resident indicated on the Elopement Risk Assessments dated 12/8 and 12/10/10 were discussed.

On 1/12/11 at 2:55 p.m., documentation was provided by Nurse Consultant #1 related to the hourly monitoring. During interview at this time, she indicated the documentation was found in the Administrator's office. The documents were entitled, "Specialized Monitoring Every Hour Observation for Wandering Residents and Sexually Inappropriate Residents" The documents indicated Resident C was monitored hourly from 12/8/10 at 5:00 p.m. until 12/13 at 11:00 p.m. An unsigned and undated notation on the document dated 12/13/10 indicated, "Interdisciplinary team deemed no longer necessary for 1 [symbol for hour] checks d/t [due to] no exit leaving behavior." On 1/12/11 at 3:45 p.m. Nurse Consultant #1 provided copy of "Unit Manager Morning Meeting Summary" dated 12/13/10 which indicated, "[name of Resident C] - continuous questions, not sleeping well...up for IDT [interdisciplinary team] review hourly [checkmark]s, [name of Resident C] [symbol for

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F 323	Continued From page 45 no] attempts @ departure elopement d/c [discontinue] please." Documentation failed to indicate the Elopement Risk Assessment and care plan were updated when the decision was made to discontinue the hourly monitoring. The Behavior Monthly Flow Record for January 2011 indicated on 1/5/11 one episode of "Non-compliance [symbol for with] smoking/smoking R/T Bx" on evening shift. On 1/6/11 indicated one episode each of "Intruding into other's rooms/offices" and "Rep [repetitive] questions" on day shift. The record included no nurse's notes after 1/6/11 at 3:00 p.m., which indicated, "...Resident up ambulating per self...No s/s [signs and symptoms] of distress noted." Social services notes for 1/6/11 indicated, "Spoke with resident's brother/POA about res's continued behavior even after returning from behavior unit. Brother stated res knows better, I'll come talk to him. I don't know what else to do with him. Discussed options including the locked down men's unit in [name of another town] that would possibly be more appropriate setting for resident. Brother stated he wanted to talk to resident, and see if he could get behaviors under control, and if not he would pursue considering another facility." Documentation failed to indicate care plans were updated at this time. On 1/12/11 at 3:25 p.m., the facility's Elopement Risk Assessment Policy was provided by the Social Worker. Review of the policy indicated, "Policy: Assess residents for potential elopement. To assure that all residents are free from harm at all times. Procedures: 1. Identify residents at	F 323		

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risk for elopement by completing the elopement risk assessment upon admission, quarterly and with significant changes in mental/psychosocial status. 2. Residents who are identified for possible elopement will immediately have interventions placed to prevent elopement...."

B. During Initial Tour of the facility on 1/11/11 between 9:50 a.m. and 11:45 a.m., various facility door alarms were observed. The Maintenance Supervisor and Nurse Consultant #2 were present intermittently during the tour and described various alarms. The facility has three floors: the ground floor, leading to a back parking lot; the first floor, with exit to the alley; and a second floor with exit through the facility lounge and front door to the street. The first floor has two exit doors into the facility's enclosed outdoor courtyard. The second floor also has an exit door from the 2-East and 2-West hallways, an exit door to the outdoor smoking patio, and a delivery door. The door alarming systems included a Wanderguard (Departure Alert System) at the facility's second floor front entrance, at elevator doors, at stairwell doors, and at the ground floor back entrance. When the doors with Wanderguards are approached by a resident wearing a Wanderguard alarm, the alarm sounded. The doors which were not connected to the Wanderguard system had battery-operated alarms or hardwire alarms and coded keypads.

During observation on 1/11/11 at 10:15 a.m., the patio gate alarm leading to the street was checked for functioning by the Maintenance Supervisor. The alarm did not sound when the Maintenance Supervisor opened the gate. During interview at this time, the Maintenance Supervisor indicated, "Someone has reset this alarm." He

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indicated he "had to get back to the beginning of the cycle" to set the alarm to function. The Maintenance Supervisor indicated the door alarm was not battery operated but hardwired into the electrical circuit.

During review of the Elopement Binder on the facility's Transitional Care Unit on 1/11/11 at 10:50 a.m., 16 residents from the facility were listed as "Residents at Risk for Elopement." During interview at this time, Nurse Consultant #2 indicated the Elopement Binder had been updated since a resident's elopement on 1/8/11, and all residents at risk for elopement were being checked every 15 minutes.

During observation on 1/11/11 at 10:40 a.m., the door alarm from the facility's secured unit, leading from the nurse's station into the facility's courtyard used by residents for supervised smoking, failed to alarm when opened by the Maintenance Supervisor. During interview at this time, the Maintenance Supervisor indicated the alarm needed a new battery. He indicated he had been busy with snow removal during the morning and had not done alarm safety checks.

During observation on 1/11/11 at 12:45 p.m., the door alarm at the end of the 2-West hall was checked by Nurse Consultant #2. The door failed to alarm when the Consultant opened it. The Consultant closed the door and opened it a second time, and the alarm did not sound. The Consultant opened the door a third time, and the alarm sounded. The Maintenance Supervisor approached, and the Consultant indicated to him that the door had a "glitch" in its function.

During interview on 1/11/11 at 1:30 p.m., the

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HILLCREST CENTRE FOR HEALTH AND REHABILITATION	203 SPARKS AVENUE JEFFERSONVILLE, IN 47130

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F 323	Continued From page 48 Consultant for Social Services/Activities indicated after a resident's elopement, on 1/10/11, the facility had ordered new door alarms for all facility doors not connected to the Wanderguard system. She indicated the facility had concerns with the current alarms. She indicated the alarms would be installed immediately upon arrival at the facility This federal tag relates to Complaint IN00084571. 3.1-45(a)(1) 3.1-45(a)(2)	F 323		